State of Colorado
Change of Election Form / Salary Reduction Plan

DPA

EMPLOYEE INFORMATION		
Employee's Name (Please Print)	Employee's Soc. Sec. No.	Dept. / Agency Org ID

ELECTION CHANGE REQUESTED

☐ **Revocation of an Existing Election**

I wish to REVOKE my existing election under the State of Colorado Salary Reduction Plan.

Type of coverage being revoked (my prior election for all other types of coverage remains in effect)

- ☐ Medical Insurance
- ☐ Dental Insurance
  - ☐ Myself
  - ☐ Spouse
  - ☐ Dependent(s) *Name(s):* _____
- ☐ Health FSA Benefits
- ☐ Dependent Care FSA Benefits

☐ **New Election**

I hereby make a new election as specified on the attached Enrollment Form. (applicable medical, dental or flexible spending account enrollment form)

THE SPECIFIED EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:

Check Applicable Box(es) to indicate the Specified Event(s) that apply to your situation, Election changes generally cannot be retroactive and must be consistent with the Specified Event, as described at the end of this Form.

A. Changes in Status

Date of Change _____

1. Change in Marital Status that Affects Eligibility.
   ☐ Marriage ☐ Divorce or annulment ☐ Legal Separation ☐ Death of spouse
2. Change in Number of Dependents Eligible for Coverage.
   ☐ Birth ☐ Adoption or Placement for Adoption ☐ Death of Dependent
3. Change in Employment Status that Affects Eligibility (employee, spouse or dependent)
   ☐ Termination of employment ☐ Commencement of employment ☐ Other
   Explain: _____
4. Change in Dependent's Eligibility Under an Employer's Plan
   ☐ Lost eligibility (such as age, student status, marital status)
   ☐ Gained eligibility (such as age, student status, marital status)
   Explain: _____
5. Change in Residence Affecting Eligibility (does not apply to Health FSA)
   Explain: _____

B. Change in Dependent Care Cost/Provider (applies to Dependent Care FSA Benefits only)

Date of Change _____

☐ Significant cost increase or decrease in rate charged by dependent care provider
☐ Changed dependent care provider

C. Other Specified Event (see Salary Reduction Plan Document for circumstances that permit a change in election)

Date of Change _____

☐ Judgment, decree or order
☐ Entitlement to Medicare or Medicaid
☐ Family Medical Leave
☐ Other
Explain: _____

SIGNATURE

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. This change of election will be approved only if it is determined to be consistent with the specified event in accordance with the Salary Reduction Plan as determined by the Administrator. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for coverage under another employer's qualified plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires individual other than me to provide accident or health coverage for my child, I certify that such coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I may appeal the decision within the time frame specified in the Salary Reduction Plan Document.

I Hereby Make the New Election Noted on the Attached Enrollment/Election Form and Attest that the Change is Made on Account of and Is Consistent with the Change in Election Event.

Employee's Signature	Date	Administrator's Signature	Date

Please make and retain a copy of this form.
Submit the original to your agency payroll and personnel administrator.

Print Reset